DPHHS-OM-300B
(Rev. 05/2016)

STATE OF MONTANA
Department of Public Health and Human Services

FAX completed form, within three (3) working days, to DPHHS TSD/NCB Network Security Unit at (406) 444-5924
If fax not available, please mail to: 111 N Sanders, Rm 204; Helena MT 59620 (Original form not required if faxed)

NON-DPHHS EMPLOYEE SYSTEM/FILE ACCESS REQUEST

*** Denotes Required Fields**

*** LEGAL Name of Individual Requiring Access:** _____
(Please Print) *First* *MI* *Last*

Logon ID: _____ **Create Logon ID:** ☐

*** Start Date:** _____ **End Date** (if applicable)**:** _____

Employed/worked with DPHHS before: ☐ **Other Name(s) Used** *(Maiden or previous married name)* _____

*** Employer:** _____ *** Work Phone:** _____

*** Work Address:** _____ **County:** _____

_____ **Job Title:** _____

*** E-mail Address:** _____ *** Date of Birth** (to be used as unique identifier)**:** _____

*** Please list access requested here:** CACFP_USER; CACFP_USER_ROLE

*** Justification** ***(Give a brief description as to why access is needed):*** The individual requiring access is a representative of a participating child care facility and will be entering claims for reimbursement using the website that interfaces with CACFP Prod 1.

CONFIDENTIALITY/CONSENT STATEMENT: ***(To be read and signed by the individual requiring access.)***

I hereby certify that I am entitled to the confidential client information to which I am requesting access. I will not release the confidential information to others unless it is for purposes directly connected to the administration of the program for whose purposes it was originally provided. Further release of this information may only be done upon authorization by the client whose privacy interest is involved or it may be released to others if specifically permitted by law. I understand that a violation of this policy may subject me to disciplinary action by my employer and may result in termination of my employer's contract with DPHHS.

I have read the DPHHS Internet Policy, Information Security & Data Access Policy, and the State of Montana's Computer Use Policies (Section PL4) and I agree to comply with all terms and conditions. These policies can be found electronically at the following link. http://dphhs.mt.gov/tsd/securityforms.aspx

I agree that all network activity conducted while doing State business and being conducted with State resources is the property of the State of Montana. I understand that the State and Department reserve the right to monitor and log ***all*** network activity including E-mail and Internet use, with or without notice, and therefore, I should have no expectations of privacy in the use of these resources.

*** Signature of Employee:** _____ **Date:** _____

*****Supervisor:*** *Access for this individual is allowed for six months. I realize I will have to contact the DPHHS Network Security Unit if this employee needs access beyond the six months. I understand that it is my responsibility to inform the DPHHS Network Security Unit immediately when this employee terminates or no longer needs access.***

Printed Name of Supervisor: _____ **Phone:** _____

Signature of Supervisor: _____ **Date:** _____

This space to be completed by Data Owner(s) *(if applicable)*

Printed Name of Data Owner: _____

Data Owner Signature: _____ **Date:** _____

Printed Name of Data Owner: _____

Data Owner Signature: _____ **Date:** _____

This space to be completed by DPHHS Network Security Unit

DPHHS Security Officer: _____ **Date:** _____